ditures for health insurance funds have been remained under control.

PCV47

ROSUVASTATIN 40 MG VERSUS ATORVASTATIN 80 MG IN HIGH-RISK PATIENTS WITH HYPERCHOLESTEROLAEMIA: ECONOMIC ANALYSIS OF THE POLARIS STUDY

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OBJECTIVES: POLARIS is a 26-week, double-blind, randomised study comparing the efficacy of rosuvastatin (RSV) 40 mg with atorvastatin (ATV) 80 mg in high-risk patients (known CHD or CHD-risk equivalent, as defined by NCEP ATP III) with hypercholesterolaemia. Using a secondary prevention model, results from POLARIS were used to estimate longer-term costs and benefits. **METHODS:** Efficacy data from POLARIS (TC, HDL-C, and TG) were used as input to the model. Markov models were run in 4-year cycles over 20 years, from age 55 to 76 years for men and women separately. Secondary CHD risk was based on Framingham data (d'Agostino et al. AHJ 2000) but calibrated to British Regional Heart Study (Brindle et al. BMJ 2003). Estimates for life expectancy, health-care costs and quality-adjusted life years (QALYs) were assigned to patients as they transitioned through the model. **RESULTS:** RSV 40 mg improved levels of TC and HDL-C more than ATV 80 mg (–41% vs. –39%; +11.0 vs. +6.2%, respectively).The model predicts that more secondary CHD events and deaths are avoided with RSV 40 mg compared with ATV 80 mg in both high-risk men and women; hence, more life-years and QALYs are generated and event costs are lower. More patients survive on treatment and therefore total costs with RSV 40 mg are slightly higher. Cost per life year gained (men: £1113, women: £1065) and QALY gained (men: £2091, women: £3079) are favourable for RSV 40 mg. **CONCLUSIONS:** RSV 40 mg is likely to be more effective both clinically and economically than ATV 80 mg for the secondary prevention of CHD.

PCV48

ASSESSMENT OF MAXIMUM LDL-C REDUCTION AND GOAL ATTAINMENT BY SWITCHING PATIENTS TO DUAL INHIBITION THERAPY (EZETIMIBE/SIMVASTATIN) IN SPAIN

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While treatment guidelines recommend lowering cholesterol to target levels, many remain above goal (LDL-C >100 mg/dL for CHD/diabetic patients and LDL-C >130 mg/dl for other non-CHD high risk individuals). **OBJECTIVE:** To assess the change in LDL-C and goal attainment rates due to switching patients to an Ezetimibe/Simvastatin dose titration strategy, compared with a simulated statin monotherapy dose titration strategy. **METHOD:** A decision-analytic model was developed to project goal attainment at end of 1-year after therapy change. Clinical trial data were used to estimate LDL-C reductions for different treatment strategies. The model was run for a population of 504 Spanish patients (237 CHD/diabetic and 267 non-CHD high risk patients) that had not reached LDL-C goal levels 3-months after starting statin therapy. Patients not at goal where up titrated (till goal attainment or to the maximum dose whichever was first) every 3 months both in the Ezetimibe/Simvastatin (only simvastatin titrated) and in the statin monotherapy titration arms. **RESULTS:** Mean age was 60.8 (SD 9.8) years, 47.8% female, lipid profile (mg/dl) at three months on statin monotherapy was LDL-C 182.3 (SD 35.1), TC 262.1 (SD 39.5), HDL-C 50.8 (SD 14.1), triglycerides 150.1 (SD 82.5). Ezetimibe/Simvastatin therapy is projected to achieve a 82.6% goal attainment rate, compared with 46.0% projected for the statin titration strategy. With respect to LDL-C reductions, Ezetimibe/Simvastatin would achieve a 38.2% reduction over baseline, compared with a 24.5% with the statin titration strategy. In the statin arm, 73.9% of the patients reached the statin maximum dose, whereas in the Ezetimibe/Simvastatin arm, only 23.5% of the patients did so. **CONCLUSION:** Compared to statin monotherapy titration, switching patients not at goal on statin monotherapy to Ezetimibe/Simvastatin followed by titration is projected to get 36.6% additional patients to goal and reduce LDL-c by 13.7%.

PCV49

BELGIAN EVALUATION OF SCREENING AND TREATMENT OF HIGH RISK PATIENTS BASED ON WAIST AND AGE (BEST)

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OBJECTIVE: The objective of this study was to describe the burden of modifiable risk factors and of the total CV risk in a population, free of CVD, selected in general practice, on the basis of age (40–75 yrs) and waist circumference (>=94 cm in men and >=80 cm in women). **METHODS:** In total, 619 Belgian GPs recruited consecutive patients during spring 2004. A central lab analysed fasting blood samples. **RESULTS:** Complete data on 8587 patients were obtained. Mean age was 58 yrs (47% women). Mean BMI and waist were 30.1 kg/m^2 and 99 cm for women and 30.1 kg/m^2 and 107 cm for men. Eighteen-percent had diabetes (D) either known and treated (14%) or newly detected, based on fasting glucose levels (4%). Of the non-diabetic subjects (ND), 25% had ≥3 metabolic syndrome risk factors (NCEP-ATP III criteria). Twenty-four percent of the total population was smoking and 84% did not engage in regular physical activity. Seventy-seven percent of ND had LDL cholesterol >=115 mg/dl & 78% of D had LDL cholesterol >=100 mg/dl. Only 31% of subjects on lipid lowering drugs had TC < 190 and LDL <115 mg/dl. 49% of ND had BP >=140/90 mmHg and 91% of the D had BP >=130/80 mmHg. Total CV risk in the ND was estimated using the SCORE chart calibrated for Belgium. Total risk >=5% for dying from CVD in the coming 10 yrs was present in more than 40% of men and in more than 20% of women. **CONCLUSION:** Waist measurement is an easy and inexpensive tool to detect, in the middle-aged population free of CVD, a subgroup with a large variety of modifiable risk factors and at high risk for CV death. A large majority of them is physically inactive, an unacceptable proportion is smoking and both total cholesterol and blood pressure are insufficiently managed.

PCV50

A MULTILEVEL ANALYSIS ON PRESCRIBED STATINES IN A BOLOGNA HEALTH AUTHORITY FROM 2000 TO 2003

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OBJECTIVES: The main aim is to evaluate the variability of practitioners' prescribing behaviour on statines in AUSL Bologna South from 2000 to 2003, as well as to quantify how much such a behaviour depends on culture, education and policy of practitioner. **METHODS:** A multilevel model has been built to reflect